

**ILLINOIS WORKERS' COMPENSATION COMMISSION
SETTLEMENT CONTRACT LUMP SUM PETITION AND ORDER**

ATTENTION. Please type or print. Answer all questions. File four copies of this form. Attach a recent medical report.

Workers' Compensation Act Occupational Diseases Act Fatal case? No Yes Date of death _____

William Tracy
Employee/Petitioner

Case # **25** WC **016634**

v.

City of Collinsville
Employer/Respondent

Setting **Collinsville, IL**

To resolve this dispute regarding the benefits due the petitioner under the Illinois Workers' Compensation or Occupational Diseases Act, we offer the following statements. We understand these statements are not binding if this contract is not approved.

Willaim Tracy
Employee's name

Street address City, State, Zip code

City of Collinsville
Employer's name

125 South Center Street, Collinsville, IL 62234
Street address City, State, Zip code

State Employee? Yes No Male Female Married Single

Dependents under age 18 Birthdate _____ Average weekly wage \$ **1,803.26**

Date of accident **05/09/2025**

How did the accident occur? **Petitioner was involved in an altercation.**

What part of the body was affected? _____

What is the nature of the injury? _____

The employer was notified of the accident orally in writing Return-to-work date **06/02/2025**

Location of accident **Collinsville, IL** Did the employee return to his or her regular job? Yes No
If not, explain below and describe the type of work the employee is doing, the wage earned, and the current employer's name and address.

TEMPORARY TOTAL DISABILITY BENEFITS: Compensation was paid for **0** weeks at the rate of \$ **N/A**/week.

The employee was temporarily totally disabled from **N/A** through **N/A**. **Petitioner was paid PEDA benefits from 5/10/2025 through 6/1/2025.**

MEDICAL EXPENSES: The employer has has not paid all medical bills. List unpaid bills in the space below.

Employer insurer have paid or will pay any and all reasonable and necessary services related to the event of 05/09/2025 in accordance with the terms and provisions of the Illinois Workers' Compensation Act and the Medical Fee Schedule therein.

PREVIOUS AGREEMENTS: Before the petitioner signed an *Attorney Representation Agreement*, the respondent or its agent offered in writing to pay the petitioner \$ **0** as compensation for the permanent disability caused by this injury.

An arbitrator or commissioner of the Commission previously made an award on this case on **N/A** regarding

TTD \$ **0** Permanent disability \$ **0** Medical expenses \$ **0** Other \$ **0**

